

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 390265	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 07/18/2023
NAME OF PROVIDER OR SUPPLIER: JEFFERSON HOSPITAL STATE LICENSE NUMBER: 711801			STREET ADDRESS, CITY, STATE, ZIP CODE: 565 COAL VALLEY ROAD, P.O. BOX 18119 JEFFERSON HILLS, PA 15025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE	
P 0000	<p>INITIAL COMMENT</p> <p>This report is the result of a follow up survey conducted on July 18, 2023, at Jefferson Regional Medical Center, d/b/a Jefferson Hospital, as the result of a previous Department of Human Services, Chapter 5100 Mental Health survey that was concluded on March 1, 2023.</p> <p>It was determined the facility was in compliance with requirements of the Chapter 5100 Mental Health regulations.</p>	P 0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:



Certified End Page

JEFFERSON HOSPITAL

STATE LICENSE NUMBER: 711801

SURVEY EXIT DATE: 07/18/2023

**I Certify This Document to be a True and Correct Statement of Deficiencies and
Approved Facility Plan of Correction for the Above-Identified Facility Survey**

A handwritten signature in black ink that reads "Jeane Parisi".

Jeane Parisi
Deputy Secretary for Quality Assurance

A handwritten signature in black ink that reads "Debra L. Bogen MD".

Debra L. Bogen, MD, FAAP
Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY